LF091405-05

PLAN AMENDMENT NO. 26

This modification is made as of the 1st day of **July, 2005**, by **City of Rapid City** to the **City of Rapid City Healthcare Plan**.

The City of Rapid City Healthcare Plan is hereby modified and the attached text may be printed on a revision page for insertion into the City of Rapid City Healthcare Plan:

Please check the following that apply:

_____ City of Rapid City will print the attached amendment for distribution.

_____ First Administrators, Inc. will print _____ copies of the attached amendment for distribution.

_____ The Plan Administrator will notify Participants of the changes in some other manner.

_____ Other: _____

City of Rapid City

_____
(Authorized Signature)

_____
(Date)

_____
(Title)

PLAN AMENDMENT NO. 26

This modification is made as of the 1st day of July, 2005
by the City of Rapid City to the City of Rapid City Healthcare Plan.
All other terms and provisions of the Plan remain unaltered and in effect.

The following text replaces S2.03 "Late Enrollment and Special Enrollment Periods" with S2.03 "Late Enrollment"
and adds S2.06 "Special Enrollment Periods" to your Benefit Book.

S2.03 LATE ENROLLMENT

If a request for employee or dependent coverage is made later than thirty-one (31) days after the employee is first eligible for employee or dependent coverage, the person requesting coverage will be considered a late applicant and must submit a written request for late enrollment to the Plan Administrator.

Late enrollment means an enrollment of an individual who enrolls under this Plan other than during: (a) the first period in which the individual is eligible to enroll under this Plan; or (b) a special enrollment period.

Late applicants, individuals not eligible for a special enrollment period, are subject to an eighteen (18) month exclusionary period. At the end of the eighteen (18) month exclusionary period late applicants are eligible to join the Plan with no Pre-Existing Condition Exclusion Period. A formal application, available from the participant's employer, must be completed to begin the eighteen (18) month exclusionary period.

S2.06 SPECIAL ENROLLMENT PERIODS

Special Enrollment rights are provided both to current employees who were eligible but declined enrollment in the Plan when first offered because they were covered under another plan and to individuals acquiring a dependent.

Dependent coverage may be obtained without submitting a written request for late enrollment within ninety (90) calendar days of the Employee's first date of full-time employment.

A special enrollment period is available to benefited employees whose regular work schedule increases from working less than forty (40) hours per week to working forty (40) or more hours per week on an active full-time basis.

If this Plan replaces similar coverage of another group plan, and an individual moves from a high deductible plan to a low deductible plan mid-year, there will be no reimbursement if the high deductible has already been met.

Pre-existing condition exclusion periods for special enrollees may not exceed twelve (12) months.

Individuals Losing Other Coverage

This Plan will permit a current employee or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if **each** of the following conditions is met:

(a) the current employee or dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;
(b) the current employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the current employee having coverage under another group health plan or due to the current employee having other health insurance coverage, but only if this Plan required such a

written statement at that time and provided the current employee with notice of the requirement (and consequences of the requirement) at that time;

(c) the current employee or dependent lost other coverage pursuant to one of the following events:
- the current employee or dependent was under COBRA and the COBRA coverage was exhausted;
- the current employee or dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, loss of dependent status, death, termination of employment, or reduction in the number of hours worked);
- the current employee or dependent moved out of an HMO service area with no other option available;
- the current employee or dependent met or exceeded a lifetime limit on all benefits (the event for reaching the lifetime limit is the earliest date that a claim is denied);
- the Plan is no longer offering benefits to a class of similarly situated individuals,
- the benefit package option is no longer being offered and no substitute is available; or
- the employer contributions were terminated; and

(d) under the terms of this Plan, the current employee requests enrollment into this Plan not later than sixty-three (63) days after an event, as described in (c) above.

Effective date for Special Enrollment: coverage must begin no later than the first day of the first calendar month as long as the written request for enrollment is made within sixty-three (63) days from loss of coverage.

Dependent Beneficiaries

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee (and, if not otherwise enrolled, the current employee, spouse and/or other eligible dependent(s) may be enrolled at the same time):

(a) if the current employee has coverage under this Plan (or the current employee has met any waiting period applicable to becoming covered under this Plan and is eligible to be enrolled under this Plan, but failed to enroll during a previous enrollment period); and

(b) if a person becomes a dependent of the current employee through marriage, birth, or adoption or placement for adoption.

The dependent special enrollment period will be a period of thirty-one (31) days beginning on the date of marriage, birth, adoption or placement for adoption.

Effective date of Enrollment (Birth, Adoption or Placement): coverage must be effective retroactively to the date of birth, adoption or replacement for adoption (Provided the written request for enrollment occurs within thirty-one (31) days of birth, adoption or placement for adoption).

Effective date of Enrollment (Spouse or Dependent acquired through marriage): coverage must be effective no later than the first day of the first month as long as the written request for enrollment is made within thirty-one (31) days of marriage.

Enrollees joining the Plan through a special enrollment period are subject to the Pre-Existing Condition Exclusion Period outlined in Section 4.06, including the right to demonstrate Creditable Coverage.

The following text adds S4.05 "Creditable Coverage Provision" and replaces S4.06 "Pre-Existing Conditions" sections of your Benefit Book.

S4.05 CREDITABLE COVERAGE PROVISION

Qualifying periods of time during which a participant or dependent had "Creditable Coverage" will be applied toward the satisfaction of the participant's or dependent's pre-existing condition exclusion period.

Prior carriers or employers will provide certification regarding a participant's or dependent's prior coverage. In addition, the participant or dependent may request a Certificate of Creditable Coverage under this Plan at any time from the Benefit Services Administrator or the Plan Administrator up to twenty-four (24) months after the participant's or dependent's coverage ceases. This certification will be used to determine what portion of the participant's or dependent's pre-existing condition exclusion period, if any, must still be satisfied.

Written requests for certificates must include:

- the name of the individual for whom the certificate is requested;
- the last date that the individual was covered under the plan;
- the name of the participant that enrolled the individual in the plan;
- a telephone number to reach the individual for whom the certificate is requested, in the event of any difficulties;
- the name of the person making the request and evidence of that person's authority to request and receive the certificate on behalf of the individual;
- the address to which the certificate should be mailed; and
- the requestor's signature.

After receiving a request that meets these requirements, the Plan will act in a reasonable and prompt fashion to provide the Certificate.

Prior coverage does not qualify under this provision if there is a break in coverage of sixty-three (63) consecutive days or more. Waiting periods are not considered periods without coverage nor are they counted as Creditable Coverage. Refer to the definition of "Creditable Coverage" in Article IX of this Plan.

As required by the Trade Act of 2002, the days between the date an individual loses group health coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

S4.06 PRE-EXISTING CONDITION EXCLUSION PERIOD

This Plan includes an exclusion period for new participants or dependents with pre-existing (not otherwise excludable) medical conditions. A pre-existing medical condition is an injury or illness which was present prior to the participant's or dependent's date of enrollment (see definition) for which any medical advice, diagnosis, care or treatment (including having a prescription for legend drugs, whether or not the drugs are taken) was provided or recommended by a physician prior to the participant's or dependent's date of enrollment. Genetic information is not treated as a pre-existing condition in the absence of a diagnosis of a condition related to the genetic information.

This provision will also be in effect if there is a change in the participant's or dependent's coverage which the participant or dependent elected to make and which increased this Plan's liability.

The pre-existing condition exclusion period works as follows:

If a participant or dependent has a pre-existing, allowable medical condition (physical or mental) within the ninety (90) day period prior to his/her date of enrollment for medical coverage (this ninety (90) day period is called the look-back period), that allowable condition will not be covered by this Plan until twelve (12) months following the participant's date of enrollment.

The twelve (12) month pre-existing condition exclusion period will be reduced by the length of the aggregate period of any creditable prior coverage.

This Plan will apply the standard method of counting creditable coverage. The standard method of counting creditable coverage determines an individual's creditable coverage without reference to specific benefits provided during the individual's prior coverage periods.

Charges incurred during the twelve (12) month pre-existing condition exclusion period will be reviewed by the Benefit Services Administrator and allowable conditions which appear to be pre-existing will be investigated.

Benefits will be available for all covered services with the exception of the allowable condition(s) specifically identified as being pre-existing.

The pre-existing condition exclusion period never applies to pregnancy, regardless of whether the woman had previous coverage. In addition, a pre-existing condition exclusion period will not be applied to a newborn, an adopted child who is under age eighteen (18) at the time of the adoption, or a child placed for adoption who is under age eighteen (18) at the time of placement for adoption, if the child becomes covered under a group health plan or other creditable coverage within thirty (30) days of the birth, adoption, or placement for adoption. This exception does not apply, however, after the child has a break in coverage of sixty-three (63) or more consecutive days.

All pre-existing condition exclusion periods (and accompanying ninety (90) day look-back periods) for *special enrollees* begin on the participant or dependent's effective date. Pre-existing condition exclusion periods (and accompanying ninety (90) day look-back periods) for *new hires* will begin on the date the participant enters a class eligible for coverage.

The following text replaces the definitions of "Creditable Coverage", "Pre-Existing Condition" and "Waiting Period" found in Article IX of your Benefit Book.

CREDITABLE COVERAGE

Creditable Coverage means coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance, including COBRA continuation coverage, or short-term "bridge" policy), Medicare Part A or B, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefit risk pool, the Federal Employees Health Benefits Plan (FEHBP), a public health plan as defined in subsequent Centers for Medicare and Medicaid Services regulations, state Children's Health Insurance Program (S-Chip), public health plans provided by a foreign country or a political subdivision and any health benefit plan under Peace Corps Act 5(e).

"Creditable Coverage" does **not** include accident or disability income, liability, workers' compensation, automobile medical insurance, health coverage for limited benefits, such as limited scope dental or vision benefits or long-term care plans, or plans under which health benefits are secondary or incidental.

PRE-EXISTING CONDITION

Pre-Existing Condition means any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day.

WAITING PERIOD

Waiting Period means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the Plan can become effective.

All references to "Wellmark Select" are hereby rescinded, and replaced with "SelectFirst™".